Risk Adjustment Services and Software

Is risk adjustment a black-box? We will help you unbox it!

We are expert at risk adjustment, from the philosophical to the technical. On the philosophical side, we can help you resolve questions such as "Why does risk adjustment often fail for atypical populations?" or "Why does risk adjustment not adjust for many non-diagnostic risks?"

Dr. Sawhney is a fully credentialed actuary and a doctor of public health. Her doctoral dissertation (2012) examined the limitations of using of risk adjustment to neutralize enrollee selection on the then-forthcoming health insurance exchanges. She has since assisted numerous consulting clients with their risk adjustment challenges.

At Teus Health, we don't believe in black boxes or expensive software. We have therefore rewritten the SAS risk adjustment scripts distributed by CMS (CMS-HCC, CMS-RX, CMS-ESRD, and CMS-PACE) into R, an open-sourced programming language. We have tested our R-software output on the Medicare 5% sample and verified that it produces the exact same output as the SAS scripts. We can also calculate HHS-HCC risk scores via R.

In addition, we tend to what goes into the calculations. Not every diagnosis code is included in risk adjustment calculations. In order to be eligible for inclusion in risk adjustment, the diagnosis code must be received from one of the three provider types in conjunction with an allowed service. If the provider is a physician, the physician must practice an allowed specialty. We have SQL scripts that apply the diagnosis eligibility rules and prepare the input files for HCC risk adjustment. We use our R and SQL scripts in-house and also license them to our clients.

Our scripts call Excel-based reference tables. Excel reference tables provide business-users quick and easy insight into the mechanics of risk adjustment. For example, a business-user only needs Excel filtering skills to see that the risk score for "HCC021 – Inflammatory Bowel Disease" ranges from 0.275 to 0.551 depending on whether the enrollee is disabled, dual, and/or institutionalized.

Finally, we have CMS Medicare FFS 5% data and a data use agreement that specifically allows us to use the data for risk adjustment benchmarking. We can therefore tell you exactly how your Medicare risk scores, and components thereof, compare to national averages and help you identify areas of potential under and over-coding.

We look forward to helping with your risk adjustment challenges.

Case Study: Why did MSSP historical costs changed without a corresponding change in historical risk scores?

Several years ago, MSSP ACOs across the country had significant changes in their historical costs, without corresponding changes in risk scores and without changes in participating physician panels.

Dr. Sawhney discovered a small and overlooked change in the MSSP attribution rules that impacted a small number of Medicare enrollees with high costs, but modest risk scores. CMS had not adequately pre-investigated the impact of the rule change.